BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
RICHARD JOSEPH CAVANAUGH, M.D. Certificate No. 20A-1477,	No. D-2230
Respondent.	L-18202

ORDER AMENDING EFFECTIVE DATE OF DECISION

The effective date of May 16, 1980 appearing in the final decision dated April 16, 1980 is hereby amended as follows:

"This Decision shall become effective on June 26, 1980."

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

Dated: May 27, 1980

By Vernon A. Leeper
VERNON A. LEEPER
Program Manager
Enforcement Unit

FL:jw

REDACTED

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
RICHARD JOSEPH CAVANAUGH, M.D. 4295 Cesner Street, #1A San Diego, California 92117	No. D-2230 L-18202
Certificate No. 20A-1477,	
Respondent.	

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43759
7-14-80

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Division of Medical Quality, Board of Medical Quality Assurance as its Decision in the above-entitled matter.

This Decision shall become effective on the 16th day of May, 1980.

IT IS SO ORDERED this 16th day of April, 1980.

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
A. DAVID AZZELRAD, M.D.
Secretary-Treasurer

jm

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
RICHARD JOSEPH CAVANAUGH, M.D. 4295 Gesner Street, #1A San Diego, California 92117	No. D-2230 L-18202
Certificate No. 20A-1477,	
Respondent.	

PROPOSED DECISION

This matter came on regularly for hearing before Marguerite C. Geftakys, Administrative Law Judge of the Office of Administrative Hearings, State of California, at Los Angeles, California, on January 7, 1980, at the hour of 9:00 a.m., and again on January 8, 9, 10 and 11, 1980, at Los Angeles; on January 14, 15, 16, 17 and 18, 21 and 22, 1980, at San Diego California; and on January 30, 1980, at Los Angeles, California. M. Gayle Askren, Deputy Attorney General, represented the complainant. Respondent Richard Joseph Cavanaugh, M.D., appeared in person on January 7, 8 and 9, 1980 and represented himself, except as set forth hereinafter, until approximately 9:40 a.m. on January 9, 1980, when he announced he would no longer appear and left the hearing room. Burton Marks, Attorney at Law, made special appearances on behalf of the respondent on January 7, 1980, at 9:00 a.m., for the purpose of making preliminary motions, and again on January 21, 1980, for the purpose of making a motion on behalf of respondent, all of which were denied.

The following amendments were made to the Accusation herein:

A. Paragraph 4G at line 5 was amended by the deletion of the number "11" and the addition by interlineation of the number "12."

B. Paragraph 5D was amended to read: "In 1969, respondent performed a surgical procedure on the patient to eliminate stretch marks on the patient's back."

C. Paragraph 5E(6) was amended to read: "The surgery performed on the patient's back is not the accepted procedure for the removal of stretch marks, and in fact, the procedure performed by respondent is unknown in plastic surgery; and"

The following amendments were made to the Supplemental Accusation herein:

A. Paragraph 10B at line 21: "face lift" was stricken, and "breast augmentation" was added by interlination.

B. Paragraph 10J(2) was deleted and the following subparagraph was added by interlineation: "(2) The use of 4-0 locking silk to close the incision of the breasts caused excessive scarring on the patient's breasts."

Evidence both oral and documentary having been received and the matter argued and submitted, the Administrative Law Judge now finds the following facts:

I

Complainant, Robert G. Rowland, is the Executive Director of the Board of Medical Quality Assurance, hereinafter referred to as "Board", and made the accusation and supplemental accusation herein solely in his official capacity.

II

On July 6, 1948, respondent Richard Joseph Cavanaugh, M.D. hereinafter referred to as "respondent", was issued osteopathic physician and surgeon certificate number 20A-1477, by the Board of Osteopathic Examiners. On July 16, 1962, respondent elected to use the designation "M.D.", and came under the jurisdiction of the Board. On June 14, 1968, pursuant to the provisions of the Board's decision in case number D-978 respondent's certificate was revoked with said revocation stayed for a period of five (5) years on certain conditions. The discipline was imposed by reason of respondent's violation of section 2399.5 of the Business and Professions Code in conjunction with section 4211 in that he did prescribe dangerous drugs without a prior medical examination or a medical indication therefor. Respondent's certificate is now and was at all times mentioned herein in full force and effect.

III

Pursuant to the provisions of sections 2360 and 2361 of the Business and Professions Code, the Division of Medical Quality of the Board may discipline any licensee who has committed any acts or omissions constituting unprofessional conduct.

IV

PATIENT JAY B[redacted]

A. On December 6, 1976, respondent performed the following surgical procedures on patient Jay B[redacted] blepheroplasty, meloplasty, a chin implant, and a forehead resection. The surgical procedures were performed under general anesthesia in a surgical suite located in respondent's office building at 9201 Sunset Boulevard, Los Angeles, California. The patient regained consciousness while in an ambulance enroute from respondent's office to a convalescent hospital. He had been given no postoperative instructions by the respondent and was not visited by the respondent at the convalescent hospital.

B. The following day, December 7, 1976, the patient was brought to respondent's office for postoperative treatment. Respondent was not present in the office, but respondent's employee, Evangeline Katz, L.V.N., removed drains from the patient's incisions, and changed dressings, pursuant to respondent's standing orders. Respondent left for Mexico on December 6, 1976 after operating on B[redacted] and did not return to the office until one or one and one-half weeks later.

C. On December 10, 1976, the patient returned to respondent's office for further postoperative care. Respondent was again not present. Ms. Katz removed the patient's eye sutures, as well as some ear, chin and forehead sutures. Ms. Katz prescribed and dispensed Empirin with Codeine No. 3 for the patient, again pursuant to respondent's standing orders.

D. On December 13, 1976, the patient returned to respondent's office for further postoperative care. Respondent was again not present. Ms. Katz removed more sutures from the patient's head and restitched the patient's forehead and area between the eyes, where the incisions had opened. Ms. Katz prescribed Tetracycline 200 mgs. for the patient.

E. On December 23, 1976, the patient returned for further care. Ms. Katz again reclosed the forehead incision, again outside of the respondent's presence.

F. On January 7, 1977, the patient again returned for postoperative care and was seen by the respondent for the first time since the December 6, 1976 surgery. Respondent resutureed the incision on his forehead and prescribed Ornade Spansules, Prednisolone 5 mgs. and Benadryl 15 mgs., for the patient.

G. On January 12, 1977, the patient returned for postoperative care. Ms. Katz removed sutures from his forehead, and dispensed Tetracycline 200 mgs. and Empirin with Codeine 30 mgs. for the patient pursuant to respondent's orders.

Respondent was present during this visit but did not see the patient.

H. On or about January 12, 1977, the patient reported to the emergency room of Cedars Sinai Hospital complaining of an abscess on the right side of his neck and an unhealed wound across his forehead. His temperature was 104 degrees. When respondent was contacted by Dr. Leo J. Lundy, Jr., of the Cedars Sinai Hospital emergency room team, he informed Dr. Lundy that he was going out of town and would be unable to take care of patient B[redacted] Respondent told Dr. Lundy to get another plastic surgeon on call to care for patient B[redacted]

I. Respondent's treatment of Jay B[redacted] constituted gross negligence and incompetence in the practice of medicine in that:

(1) Respondent was unavailable for postoperative care of the patient, starting immediately after the operation, and continuing until the patient's admission to Cedars Sinai Hospital;

(2) Respondent failed to prepare adequate operative records which would permit another physician to properly monitor the patient's postoperative recovery;

(3) Respondent permitted Ms. Katz, a licensed vocational nurse, to perform surgical procedures in his office, as well as to prescribe medications for his patients;

(4) Respondent permitted Ms. Katz to prescribe Tetracycline for the patient, which is contraindicated in this situation, in that the Tetracycline suppressed some of the bacteria, but allowed the staphylococcus organism to grow and eventually manifest itself in the patient's neck abscess;

(5) Respondent removed excess skin from the forehead which made it difficult for the forehead incision to heal, and caused its repeated reopening; and

(6) Respondent removed too much skin from both lower eyelids, so that the patient will require full thickness skin grafts to correct the bilateral ectropion

V

PATIENT MARGIE D[redacted] V[redacted] (now G[redacted])

A. On October 5, 1973, respondent performed a bilateral reduction mammoplasty on Margie D[redacted] V[redacted], a patient who had had silicone injection to her breasts approximately five (5) years prior by respondent. The surgery occurred in respondent's office, under general anesthesia administered by a nurse anesthetist.

B. Thereafter, starting on or about October 15, 1973, and continuing through the end of October 1973, the patient's breasts were infected, with blood and puss oozing therefrom. Respondent prescribed Tetracycline to treat the infection. At no time did respondent perform a culture and sensitivity test of the wounds to determine the nature of the bacteria.

C. On October 16, 1973, respondent performed a surgical procedure for the removal of abdominal scars by excising the scars themselves. Respondent charged $2,500 for the mammoplasty and abdominal scar removal surgical procedure.

D. In 1969, respondent performed a surgical procedure on the patient to eliminate three stretch marks on the patient's lower back by excising the scars.

E. Respondent's treatment of Margie D[redacted] V[redacted] constituted gross negligence and gross incompetence in the practice of medicine, in that:

(1) The performance of a reduction mammoplasty on a patient who has had silicone injections, in an office setting, with only a nurse anesthetist present, was extremely hazardous;

(2) In performing the surgery, respondent removed excess amount of nipple and areola, and placed the nipples too high at about 16 centimeters from the supra sternal notch with the left being placed 1.5 centimeters higher than the right. Also, the breasts have a marked teardrop appearance and are extremely deformed.

(3) Respondent failed to take a culture and sensitivity test of the breast wounds to determine the nature of the patient's infection. Instead, respondent prescribed Tetracycline, which is not the drug of choice for a postoperative wound infection.

(4) Respondent performed abdominal surgery on the patient at a time when her breast wounds were not yet healed, and an infection was present;

(5) The abdominal surgery performed by the respondent is not the accepted surgery for the removal of abdominal scars. The procedure performed by the respondent is unknown in plastic surgery;

(6) The surgery performed on the patient's back is not the accepted procedure for the removal of stretch marks, and in fact, the procedure performed by respondent is unknown in plastic surgery; and

(7) Respondent failed to maintain any records whatsoever regarding the patient's back surgery. The records pertaining to the patient's breast and abdominal surgeries are grossly inadequate, so as to make it impossible for another physician to monitor the patient's postoperative progress.

VI

A. During the period between 1973 and November 1977, respondent permitted his employee, Evangeline Katz, L.V.N., pursuant to orders, direct and standing, to prescribe and inject dangerous drugs and to suture incisions of respondent's patients in respondent's office, both in and out of respondent's presence.

B. Specifically, Evangeline Katz, L.V.N., prescribed and administered medication and sutured incisions for patient Jay B[redacted], as more particularly found hereinabove at paragraphs IV-B through IV-G.

C. Evangeline Katz, L.V.N., has not at any time been licensed as a physician and surgeon.

D. Evangeline Katz was first licensed in February of 1974 by the Board of Vocational Nurse and Psychiatric Technician Examiners.

VII

PATIENT MARY P[redacted]

A. On July 21, 1977, respondent performed an abdominal lipectomy on patient Mary P[redacted] under general anesthesia in his offices at 4295 Gesner Street, #1A, San Diego, California. Respondent never saw or examined the patient prior to the day of surgery. Respondent charged Mary P[redacted] $2,500 for said surgery, less a $500 professional discount.

B. Respondent's surgery on Mary P[redacted] constituted gross negligence in the practice of medicine, as more particularly alleged hereinafter:

(1) The lower abdominal incision was much too short, so as to make it impossible to remove as much excess skin and fat as is required to achieve an acceptable result.

(2) The respondent failed to remove all the skin and fat from the hairline up to the umbilicus, so that the vertical midline abdominal scar resulting from a tubal ligation could not be removed, and the patient was left with a fresh scar in addition to the pre-existing one.

(3) The patient was left with a protuberant abdomen, excessive stretch marks, and two vertical scars on her abdomen. The patient required corrective surgery in order to eliminate these problems. Said corrective surgery was performed by a board certified plastic surgeon.

VIII

PATIENT MARY W[redacted] (now K[redacted])

A. On or about April 3, 1978, respondent performed a bilateral augmentation mammoplasty on Mary W[redacted], now Mary W[redacted] K[redacted]. Said operation was performed 23 days following Mrs. W[redacted] giving birth to a baby on March 11, 1978.

B. Following the surgery, the patient repeatedly complained to respondent of pain in her breasts. Respondent informed her that there was nothing that could be done.

C. Respondent's treatment of Mary W[redacted] constituted gross negligence in the practice of medicine in that:

(1) The performance of an augmentation mammoplasty 23 days postpartum increased the likelihood of a breast infection, and of significant bleeding, since the breasts are engorged with milk and extremely tender at this time.

(2) Respondent placed the right implant too high, because he did not do adequate dissection. As a result, the patient had marked asymmetry in her breasts.

(3) Respondent failed to explore the breasts for infection, despite the patient's continued complaints to respondent of pain. The implants were removed on April 21, 1978 by a board certified plastic surgeon, at which time the patient had a possible pathogen, staphylococcus epidermitis, in the left breast cavity.

IX

PATIENT LINDA P[redacted]

A. On February 17, 1977, respondent performed an augmentation mammoplasty on Linda P[redacted] in his office at 4295 Gesner Street, #1A, San Diego, under a general anesthesia administered by his employee, Gail Koos, R.N. Respondent did not see or examine the patient prior to the day of surgery.

B. On February 28, 1977, respondent's nurse, Gail Koos, removed the sutures from the patient's incisions. The nurse also administered Kenalog 20 mg., pursuant to respondent's standing order for all augmentation mammoplasty patients of monthly injections of Kenalog for a period of one year after surgery.

C. On April 1, 1977, and May 3, 1977, nurse Koos administered further injections of Kenalog 20 mg.

D. Respondent's treatment of Linda P[redacted] constituted gross negligence and incompetence in the practice of medicine, as more particularly found hereinafter:

(1) Respondent placed the implants much too high and far too laterally, creating a marked deformity of the breasts.

(2) Respondent placed the incisions well below the inframammary crease, and quite lateral to the breasts, creating a marked cosmetic deformity. In addition, the incisions were longer than necessary, creating larger scars.

(3) The sutures were left in the patient for eleven days, and were tight, resulting in hash marks going across the full length of the incision scars.

(4) The Kenalog injections were unnecessary in that capsular contraction cannot be prevented by cortisone in augmentation mammoplasty.

X

PATIENT ANNA LYNNE D[redacted]

A. On January 7, 1977, Ms. D[redacted] consulted respondent about the appearance of her breasts. She expressed dissatisfaction with the sagging condition of her breasts. Respondent recommended that she undergo an augmentation mammoplasty.

B. On January 21, 1977, respondent performed a bilateral augmentation mammoplasty and modified face lift on the patient for a fee of $2,100. The surgery was performed under general anesthesia in respondent's office at 4295 Gesner Street, #1A, San Diego, California. In performing the breast augmentation, respondent closed the skin with 4-0 locking silk.

C. The patient was seen postoperatively at home by respondent's nurse Gail Koos. On February 1, 1977, there was bleeding from the operative area in her right breast, and nurse Gail Koos, in respondent's absence, attempted to aspirate the blood with a needle.

D. On February 3, 1977, nurse Koos examined the patient and found that the right side was still draining. Respondent was not present.

E. On Feburary 12, 1977, the patient was seen by respondent in his office. Respondent resutured the opening in the incision in the right breast. Nurse Koos administered an injection of Kenalog 40 mg.

F. On March 3, 1977, respondent removed the right implant in his office. However, respondent was advised by nurse Koos two weeks prior thereto that the implant was exposed.

G. On March 17, 1977, the operative area on the right side was still draining and the sutures were removed by nurse Koos.

H. The patient was not seen again by respondent until Ju. 10, 1977, at which time the remaining left implant was removed, and 550 cc. implants were placed in both breasts. Respondent obtained hemostasis by pressure during the surgery. Following surgery, the incision was closed with running suture, and the skin with locking silk. On June 21, 1977, the patient returned for postoperative care. She had a hematoma on the left side, which respondent's nurse Gail Koos and assistant Robert Britton attempted to aspirate with a needle.

I. On June 23, 1977, the operative area on the left side was still open when the sutures were removed by Nurse Koos pursuant to standing orders. On June 28, 1977, there was still drainage and a raw area on the left breast.

J. Respondent's treatment of Anna Lynne D[redacted] constituted gross negligence and incompetence in the practice of medicine, in that:

(1) The operation recommended by respondent, bilateral augmentation mammoplasty, could not possibly improve the patient's condition, which was one of sagging breasts.

(2) The use of 4-0 locking silk to close the incision of the breasts caused excessive scarring on the patient's breasts.

(3) The patient did not receive postoperative care from the respondent following her surgery in that she was not seen by him for approximately three weeks postoperatively, despite the fact that bleeding from the operative area was noted. Additionally, respondent permitted his nurse to attempt needle aspiration which poses a danger of puncturing a breast implant.

(4) Respondent resutured the wound three weeks postoperatively, without enlarging the pocket or reducing the size of the implants, which caused the wound to reopen.

(5) The Kenalog injection was contraindicated in the presence of problems with wound healing, in that Kenalog delays wound healing.

(6) Respondent failed to render post-operative care to the patient following the March 3, 1977, operation, despite the fact that the operative area was still draining as of March 17, 1977.

(7) The 550 cc. size of implants was grossly excessive for this patient.

(8) During the June 10, 1977, surgery respondent obtained hemostatis by pressure, which is inadequate and likely to result in a hematoma.

(9) Respondent should have used interrupted sutures rather than running sutures, in that running sutures are much less secure, and the patient had already had a history of healing problems.

(10) The use of locking silk suture on the skin produces unnecessary scarring.

(11) Respondent permitted the removal of the sutures following the June 10, 1977, operation despite the fact that the incision on the left breast was still open.

XI

PATIENT NGUYEN H[redacted]

A. On February 21, 1978, respondent performed a nose

implant on Nguyen H[redacted] and recommended that Mr. H[redacted] have a nose implant installed, and performed the surgery that same day.

B. Following surgery respondent placed a plaster cast over Mr. H[redacted] nose, to hold the implant in place. Shortly after the surgery the implant came loose and moved to the left side of his nose.

C. Respondent's treatment of Nguyen H[redacted] constituted incompetence in the practice of medicine, in that respondent failed to suture the implant in place, and relied instead upon an external device, which was inadequate for securing the implant.

XII

PATIENT MERCEDES M[redacted]

A. On or about November 11, 1976, respondent performed a chemical peel on Mercedes M[redacted] forehead. Following the operation, the patient's forehead was taped, and the tape left on for six days. On or about November 13, 1976, a chemical peel was performed by respondent on the rest of her face. This time, her face was taped until on or about November 18, 1976.

B. The patient has areas of discoloration throughout her face.

C. Respondent's treatment of Mercedes M[redacted] constituted gross negligence and incompetence in the practice of medicine, in that:

(1) Mrs. M[redacted] face was taped much too long following the chemical face peels, resulting in a partial thickness burn over her face. The standard of practice in the local community of plastic surgeons as it relates to chemical face peels is to remove the tape after two days under light sedation.

(2) Mrs. M[redacted] has dark skin. Chemical face peels are not indicated for dark skinned people, such as Mrs. M[redacted] because they result in variable pigmentation.

XIII

A. From November 1, 1976 to the end of the year, respondent rented office space in Encinitas on Wednesdays and Thursdays where he alternated his practice of plastic surgery with his practice one or two days a week at 9201 Sunset Boulevard, Los Angeles. Respondent moved his Encinitas office on or about January 1, 1977 to 4295 Gesner Street, #1A, San Diego, and his Sunset Boulevard office in April of 1977 to Encino, California. Respondent no longer has offices in San Diego.

B. Respondent usually arrived in the San Diego office the day ahead of surgery but rarely ever saw patients the day before surgery. Three or four surgeries were scheduled for the same day, when respondent usually first saw the patient. He delegated the pre-operative interviews to his business partner, a person not licensed in the healing arts by the State of of California.

C. Respondent delegated the postoperative care of his San Diego patients to nurse Koos, who was to execute respondent's standing orders as listed substantially below. Respondent usually remained in the San Diego area one or two days after surgery but did not see patients unless there was a problem. Nurse Koos was under the following standard orders by respondent:

1. Nurse Koos was to remove the sutures on or about the tenth day after breast augmentation mammoplasty;

2. Nurse Koos was to give monthly Kenalog injections to all augmentation mammoplasty for a period of one year to prevent fibrous content around the implant;

3. Percodan and Demerol, both analgesics, were to be sent with the patient after surgery to the convalescent home.

D. Nurse Katz was required by respondent to render substantially all of the postoperative care of his surgical patients. She was ordered to carry out the following orders, inter alia:

1. Eye sutures were to be removed three to four days after surgery; ear sutures were to be removed five to six days after surgery; head sutures were to be removed ten to twelve days after surgery. Drill scalp and insert hair plugs.

2. Prescribe and dispense Emperin with Codeine No. 3, Tetracycline, Valium and Demerol.

XIV

Respondent has manifested an utter disregard for the welfare of his patients referred to hereinabove. Each of said patients has suffered greviously, physically, emotionally, and financially by reason of respondent's gross negligence and incompetence, gross or otherwise.

XV

Respondent's current mailing address is 22713 Ventura Boulevard, Suite F, Woodland Hills, California 90164, (a post office box.)

XV

All allegations not found to be true are found not to have been established by the evidence.

* * * * *

Pursuant to the foregoing findings of fact, the Administrative Law Judge makes the following determination of issues:

I

Respondent is subject to discipline pursuant to the provisions of section 2361(b) of the Business and Professions Code in that respondent has committed acts of gross negligence as set forth in Findings IV, V, VII, VIII, IX, X, and XII, hereinabove.

II

Respondent is subject to discipline pursuant to the provisions of section 2361(d) of the Business and Professions Code in that respondent has committed acts of incompetence as set forth in Findings IV, IX, X, XI and XII, hereinabove.

III

Respondent is subject to discipline pursuant to the provisions of section 2361(c) of the Business and Professions Code, effective prior to January 1, 1975, in that he has committed acts of gross incompetence as set forth in Finding V, hereinabove.

IV

Respondent is subject to discipline pursuant to the provisions of section 2361, subdivision (a) of the Business and Professions Code, in conjunction with section 2141 of the Business and Professions Code, in that respondent has aided and abetted the unlicensed practice of medicine as set forth in Finding VI, hereinabove.

* * * * *

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate number 20-A-1477 heretofore issued to Richard Joseph Cavanaugh, M.D., is hereby revoked. separately

and severally, as to each and every ground for disciplinary action set forth in the Determination of Issues, hereinabove.

I hereby submit the foregoing which constitutes my Proposed Decision in the above-entitled matter as a result of the hearing had before me on the above dates at Los Angeles and San Diego, California, and recommend its adoption as the decision of the Board of Medical Quality Assurance.

DATED: FEB 13 1980

MARGUERITE C. GEPHARTS
Administrative Law Judge
Office of Administrative Hearings

MCG:jm

EVELLE J. YOUNGER, Attorney General
DORA LEVIN
Deputy Attorney General
3580 Wilshire Boulevard
Los Angeles, California 90010
Telephone: (213) 736-2004

Attorneys for Complainant

REDACTED

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against:	NO. D-2230
RICHARD JOSEPH CAVANAUGH, M.D. 4295 Gesner Street, #1A San Diego, California Certificate No. 20A-1477, Respondent.	ACCUSATION

Complainant alleges that:

1. Complainant, Robert G. Rowland, is the Executive Director of the Board of Medical Quality Assurance (hereinafter referred to as "Board") and makes this accusation solely in his official capacity.

2. On or about July 6, 1948, respondent Richard Joseph Cavanaugh, M.D. (hereinafter referred to as "respondent") was issued Osteopathic Physician and Surgeon Certificate No. 20A-1477, by the Board of Osteopathic

Examiners. On or about July 15, 1962, respondent elected to use the designation "M.D.," and came under the jurisdiction of the Board. On or about June 14, 1968, pursuant to the provisions of the Board's decision in case number D-978 respondent's certificate was subjected to discipline. A true and correct copy of said decision number D-978 is attached hereto and incorporated herein as though fully set forth. Respondent's certificate is now and was at all times mentioned herein in full force and effect.

3. Pursuant to the provisions of sections 2360 and 2361 of the Business and Professions Code, the Division of Medical Quality of the Board may discipline any licensee who has committed any acts or omissions constituting unprofessional conduct.

4. Respondent is subject to discipline pursuant to the provisions of section 2361, subdivisions (b) and (d) of the Business and Professions Code, in that respondent has committed acts of gross negligence and incompetence in his treatment of Jay B[redacted], as more particularly alleged hereinafter:

A. On or about December 6, 1976, respondent performed the following surgical procedures on patient Jay B[redacted] blepheroplasty, meloplasty, a chin implant, and a forehead resection. The surgical procedures were performed in respondent's office, under general anesthesia. The patient regained consciousness while in an ambulance en route from respondent's office to a convalescent hospital. He had

been given no postoperative instructions by the respondent and was not visited by the respondent at the convalescent hospital.

B. The following day, December 7, 1976, the patient was brought to respondent's office for postoperative treatment. Respondent was not present in the office, but respondent's employee, Evangeline Katz, L.V.N., removed drains from the patient's incisions, and changed dressings.

C. On or about December 10, 1976, the patient returned to respondent's office for further postoperative care. Respondent was again not present. Ms. Katz removed the patient's eye sutures, as well as some ear, chin and forehead sutures. Ms. Katz prescribed empirin with Codeine No. 3 for the patient.

D. On or about December 13, 1976, the patient returned to respondent's office for further postoperative care. Respondent was again not present. Ms. Katz removed more sutures from the patient's head and restiched the patient's forehead and area between the eyes, where the incisions had opened. Ms. Katz prescribed Tetracycline 200 milligrams for the patient.

E. On or about December 23, 1976, the patient returned for further care. Ms. Katz again reclosed the forehead incision, again outside of the respondent's presence.

F. On or about January 7, 1977, the patient again returned for postoperative care, and Ms. Katz again resutured

the incision on his forehead. Ms. Katz prescribed Ornade Spansules, Prednisolone 5 milligrams and Benadryl 15 milligrams, for the patient. Again, respondent was not present during this visit.

G. On or about January 11, 1977, the patient returned for postoperative care. Ms. Katz removed sutures from his forehead, and prescribed Tetracycline 250 milligrams and empirin with Codeine 30 milligrams for the patient. Respondent was not present during this visit.

H. On or about January 12, 1977, the patient reported to the emergency room of Cedars Sinai Hospital complaining of an abscess on the right side of his neck and an unhealed wound across his forehead. When respondent was contacted by hospital personnel, he informed them that he was leaving the country, and would be unable to supervise the care of the patient.

I. Respondent's treatment of Jay B[redacted] constituted gross negligence and incompetence in the practice of medicine, as more particularly alleged hereinafter:

(1) Respondent was unavailable for postoperative care of the patient, starting immediately after the operation, and continuing until the patient's admission to Cedars Sinai Hospital;

(2) Respondent failed to prepare adequate operative records which would permit another physician to properly monitor the patient's postoperative recovery;

(3) Respondent permitted Ms. Katz, a licensed vocational nurse, to perform surgical procedures in his office, as well as to prescribe medications for his patients;

(4) Respondent permitted Ms. Katz to prescribe Tetracycline for the patient, which is contraindicated in this situation, in that the Tetracycline suppressed some of the bacteria, but allowed the staphylococcus organism to grow and eventually manifest itself in the patient's neck abscess;

(5) Respondent removed excess skin from the forehead which made it difficult for the forehead incision to heal, and caused its repeated reopening; and

(6) Respondent removed too much skin from both lower eyelids, so that the patient will require full thickness skin grafts to correct the bilateral ectropion.

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5. Respondent is further subject to discipline pursuant to the provisions of section 2361, subdivisions (b) and (c) of the Business and Professions Code[1], in that respondent has committed acts of gross negligence and gross incompetence in his treatment of Margie D[redacted]V[redacted], as more particularly alleged hereinafter:

A. On or about October 5, 1973, respondent performed a bilateral reduction mammaplasty on Margie DeV[redacted], a patient who had had silicone injection to her breasts approximately five years prior. The surgery occurred in respondent's office, under general anesthesia administered by a nurse anesthetist.

B. Starting on or about October 15, 1973, and continuing through the end of October 1973, the patient's breasts were infected. Respondent prescribed Tetracycline to treat the infection. At no time did respondent perform a culture and sensitivity test of the wounds to determine the nature of the bacteria.

C. On or about October 16, 1973, respondent performed a surgical procedure for the removal of abdominal scars.

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1. Prior to January 1, 1975, section 2361, provided, inter alia, ". . . unprofessional conduct includes, but is not limited to the following . . . (c) gross incompetence." Effective January 1, 1975, said section was amended to read, inter alia, "Unprofessional conduct includes but is not limited to the following . . . (c) incompetence." Effective January 1, 1976, subdivision (c) of section 2361 was relettered subdivision (d).

D. At approximately the same time, respondent performed a third surgical procedure on the patient, to eliminate sagging skin on the patient's lower back and buttocks.

E. Respondent's treatment of Margie D[redacted] constituted gross negligence and gross incompetence in the practice of medicine, as more particularly alleged hereinafter:

(1) The performance of a reduction mammaplasty on a patient who has had silicone injections, in an office setting, with only a nurse anesthetist present, was extremely hazardous;

(2) In performing the surgery, respondent removed excess amounts of nipple and areola, and placed the nipples too high, with the left being placed 1.5 centimeters higher than the right. Also, the breasts have a marked teardrop appearance;

(3) Respondent failed to take a culture and sensitivity test of the breast wounds to determine the nature of the patient's infection. Instead, respondent prescribed Tetracycline, which is not the drug of choice for a postoperative wound infection;

(4) Respondent performed abdominal surgery on the patient at a time when her breast wounds were not yet healed, and an infection was present;

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(5) The abdominal surgery performed by the respondent is not the accepted surgery for the removal of abdominal scars. The procedure performed by the respondent is unknown in plastic surgery;

(6) The surgical procedure performed on the patient's back is not the accepted procedure for the removal of sagging skin, and in fact, the procedure performed by the respondent is unknown in plastic surgery; and

(7) Respondent failed to maintain any records whatsoever regarding the patient's back surgery. The records pertaining to the patient's breast and abdominal surgeries are grossly inadequate, so as to make it impossible for another physician to monitor the patient's postoperative progress.

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6. Respondent is further subject to discipline pursuant to the provisions of section 2361, subdivision (a), of the Business and Professions Code, in conjunction with section 2141 of the Business and Professions Code, in that respondent has aided and abetted the unlicensed practice of medicine, as more particularly alleged hereinafter:

A. During the period between 1973 and November 1977, respondent permitted his employee, Evangeline Katz, L.V.N., to prescribe and inject dangerous drugs and to suture incisions of respondent's patients in respondent's office, both in and out of respondent's presence.

B. Specifically, Evangeline Katz, L.V.N., prescribed and administered medication and sutured incisions for patient Jay B[redacted], as more particularly alleged hereinabove at paragraphs 4B through 4G.

C. Evangeline Katz, L.V.N., has not at any time been licensed as a physician and surgeon.

WHEREFORE, complainant requests that a hearing be held on the matters alleged herein, and that following said hearing, the Division of Medical Quality issue a decision:

1. Suspending or revoking respondent's physician's and surgeon's certificate; and

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2. Taking such other action as the Division deems proper.

DATED: September 19, 1978

ROBERT G. ROWLAND
Executive Director
Board of Medical Quality Assurance

Complainant

REDACTED

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Attorneys for Complainant

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

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BMQA
L 43754
7-14-83

In the Matter of the Accusation Against:	NO. D-2230
RICHARD JOSEPH CAVANAUGH, M.D. 4295 Gesner Street, #1A San Diego, California 92117	SUPPLEMENTAL ACCUSATION
Certificate No. 20A-1477,	
Respondent.	

Complainant further alleges that:

7. Respondent is further subject to discipline pursuant to the provisions of section 2361, subdivision (b), of the Business and Professions Code, in that respondent has committed acts of gross negligence in his treatment of Mary Price, as more particularly alleged hereinafter:

A. On or about July 21, 1977, respondent performed an abdominal lipectomy on patient Mary P[redacted]. Respondent never saw or examined the patient prior to

the day of surgery.

B. Respondent's surgery on Mary P[redacted] constituted gross negligence in the practice of medicine, as more particularly alleged hereinafter:

(1) The lower abdominal incision was much too short, so as to make it impossible to remove as much excess skin and fat as is required to achieve an acceptable result.

(2) The respondent failed to remove all the skin and fat from the hairline up to the umbilicus, so that the vertical midline abdominal scar, resulting from the patient's prior cesarean section, could not be removed, and the patient was left with a fresh vertical scar in addition to the pre-existing one.

(3) The patient was left with a protuberant abdomen, excessive stretch marks, and two vertical scars on her abdomen. The patient required corrective surgery in order to eliminate these problems.

8. Respondent is further subject to discipline pursuant to the provisions of section 2361, subdivision (b), of the Business and Professions Code, in that respondent has committed acts of gross negligence in his treatment of Mary W[redacted], as more particularly alleged hereinafter:

A. On or about April 3, 1978, respondent performed an augmentation mammoplasty on Mary W[redacted].

Said operation was performed ten days following Mrs. W[redacted] giving birth to a baby.

B. Following the surgery, the patient repeatedly complained to respondent of pain in her breasts. Respondent informed her that there was nothing that could be done.

C. Respondent's treatment of Mary W[redacted] constituted gross negligence in the practice of medicine, as more particularly alleged hereinafter:

(1) The performance of an augmentation mammoplasty ten days postpartum increased the likelihood of a breast infection, and of significant bleeding, since the breasts are engorged with milk and extremely tender at this time.

(2) Respondent placed the right implant too high, because he did not do adequate dissection. As a result, the patient had marked asymmetry in her breasts.

(3) Respondent failed to explore the breasts for infection, despite the patient's continued complaints to respondent of pain. Upon removal of the implants, the patient had an infection in the left breast cavity.

9. Respondent is further subject to discipline pursuant to the provisions of section 2361, subdivisions (b) and (d), of the Business and Professions Code, in that

respondent has committed acts of gross negligence and incompetence in his treatment of Linda P[redacted] as more particularly alleged hereinafter:

A. On or about February 17, 1977, respondent performed an augmentation mammoplasty on Linda P[redacted]. Respondent did not see or examine the patient prior to the day of surgery.

B. On or about February 28, 1977, respondent's nurse removed the su ces from the patient's incisions. The nurse also administered Kenalog 20 mg.

C. On or about April 1, 1977, and on or about May 3, 1977, the nurse administered further injections of Kenalog 20 mg.

D. Respondent's treatment of Linda P[redacted] constituted gross negligence and incompetence in the practice of medicine, as more particularly alleged hereinafter:

(1) Respondent placed the implants much too high and far too laterally, creating a marked deformity of the breasts.

(2) Respondent placed the incisions well below the inframammary creese, and quite lateral to the breasts, creating a marked cosmetic deformity. In addition, the incisions were longer than necessary, creating larger scars.

(3) The sutures were left in the

patient for eleven days, and were tight, resulting in hash marks going across the full length of the incision scars.

(4) The Kenalog injections were unnecessary.

10. Respondent is further subject to discipline pursuant to the provisions of section 2361, subdivisions (b) and (d), of the Business and Professions Code, in that respondent has committed acts of gross negligence and incompetence in his treatment of Anna Lynne D[redacted], as more particularly alleged hereinafter:

A. On or about January 7, 1977, Ms. D[redacted] consulted respondent about the appearance of her breasts. She expressed dissatisfaction with the sagging condition of her breasts. Respondent recommended that she undergo an augmentation mammoplasty.

B. On or about January 21, 1977, respondent performed a bilateral augmentation mammoplasty and modified face lift on the patient. In performing the face lift, respondent closed the skin with 4-0 locking silk.

C. The patient returned for several postoperative visits, where she was seen by respondent's nurse. On or about February 1, 1977, there was bleeding from the operative area in her right breast, and the nurse attempted to aspirate the blood

with a needle.

D. On or about February 3, 1977, the nurse examined the patient and found that the right side was still draining.

E. On or about February 12, 1977, the patient was seen by respondent. Respondent resutured the opening in the incision in the right breast. He also administered an injection of Kenalog 40 mg.

F. On or about March 3, 1977, respondent removed the right implant.

G. On or about March 17, 1977, the operative area on the right side was still draining.

H. The patient was not seen again by respondent until June 10, 1977, at which time the remaining left implant was removed, and 550 cc. implants were placed in both breasts. Respondent obtained hemostasis by pressure during the surgery. Following surgery, the incision was closed with running suture, and the skin with locking silk. On or about June 21, 1977, the patient returned for postoperative care. She had a hematoma on the left side, which respondent's nurse attempted to aspirate with a needle.

I. On or about June 23, 1977, the operative area on the left side was still open. On or about June 28, 1977, the sutures were removed.

J. Respondent's treatment of Anna Lynne D[redacted] constituted gross negligence and incompetence in

the practice of medicine, as more particularly alleged hereinafter:

(1) The operation recommended by respondent, bilateral augmentation mammoplasty, could not possibly improve the patient's condition, which was one of sagging breasts.

(2) The use of 4-0 locking silk to close the incision of the face lift caused excessive scarring on the patient's face.

(3) The patient did not receive postoperative care from the respondent following her surgery in that she was not seen by him for approximately three weeks postoperatively, despite the fact that bleeding from the operative area was noted. Additionally, respondent permitted his nurse to attempt needle aspiration which poses a danger of puncturing a breast implant.

(4) Respondent resutured the wound three weeks postoperatively, without enlarging the pocket or reducing the size of the implants, which caused the wound to reopen.

(5) The Kenalog injection was contraindicated in the presence of problems with wound healing, in that Kenalog delays wound healing.

(6) Respondent failed to render postoperative care to the patient following the

March 3, 1977, operation, despite the fact that the operative area was still draining as of March 17, 1977.

(7) The 550 cc. size of implants was grossly excessive for this patient.

(8) During the June 10, 1977, surgery respondent obtained hemostasis by pressure, which is inadequate and likely to result in a hematoma.

(9) Respondent should have used interrupted sutures rather than running sutures, in that running sutures are much less secure, and the patient had already had a history of healing problems.

(10) The use of locking silk suture on the skin produces unnecessary scarring.

(11) Respondent removed the sutures following the June 10, 1977, operation despite the fact that the incision on the left breast was still open.

11. Respondent is further subject to discipline pursuant to the provisions of section 2361, subdivision (d), of the Business and Professions Code, in that respondent has committed acts of incompetence in his treatment of Nguyen H[redacted], as more particularly alleged hereinafter:

A. On or about February 21, 1978, Mr. H[redacted] accompanied a friend to respondent's office, where the friend was scheduled for treatment. Respondent

recommended that Mr. H[redacted] have a nose implant installed, and performed the surgery that same day.

B. Following the surgery respondent placed a plaster cast over Mr. H[redacted]s nose, to hold the implant in place. Shortly after the surgery the implant came loose and moved to the right side of his nose.

C. Respondent's treatment of Nguyen H[redacted] constituted incompetence in the practice of medicine, as more particularly alleged hereinafter:

(1) Respondent failed to suture the implant in place, and relied instead upon an external device, which was inadequate for securing the implant.

12. Respondent is further subject to discipline pursuant to the provisions of section 2361, subdivisions (b) and (d), of the Business and Professions Code, in that respondent has committed acts of gross negligence and incompetence in his treatment of Mercedes M[redacted], as more particularly alleged hereinafter:

A. On or about November 11, 1976, respondent performed a chemical peel on the patient's forehead. Following the operation, the patient's forehead was taped, and the tape left on for six days. On or about November 13, 1976, a chemical peel was performed by respondent on the rest of her face. This time, her face was taped until on or about November 18, 1976.

B. The patient has areas of discoloration

throughout her face.

C. Respondent's treatment of Mercedes M[redacted] constituted gross negligence and incompetence in the practice of medicine, as more particularly alleged hereinafter:

(1) Mrs. M[redacted] face was taped much too long following the chemical face peels, resulting in a partial thickness burn over her face.

(2) Chemical face peels are not indicated for dark skinned people, such as Mrs. M[redacted] because they result in variable pigmentation.

WHEREFORE, complainant requests that a hearing be held on the matters alleged herein, and that following said hearing the Division of Medical Quality issue a decision:

1. Suspending or revoking respondent's physician's and surgeon's certificate; and

2. Taking such other action as the division deems proper.

DATED: November 14, 1978.

ROBERT G. ROWLAND
Executive Director
Board of Medical Quality Assurance
State of California

Complainant

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